SECTION I – ALL RESTRAINTS (* = Required Field)

*(1) Individual: First Name: _____ Last Name: _____

*(2) Reporting Provider: _____ *(3) Area Office/Facility: _____

*(4) Provider Location: _____

*(5) Order Date: _____ *(6) Type of Restraint Order: (6A) Initial: ☐ (6B) Renewal: ☐ (6C) Hold: ☐

*(7) Time of:
(7A) Initial Restraint: _____ am/pm (7B) Restraint Renewal: _____ am/pm (7C) Restraint Removal: _____ am/pm

*(8) Name of Staff Identifying Emergency: _____ (9) Position of Staff Identifying Emergency: _____

*(10) Describe Emergency Situation:

_____

_____

_____

_____

_____

_____

*(11) Categorize Emergency Situation (check all that apply):

(11A) ☐ Substantial Risk of Serious Physical Assault

(11B) ☐ Occurrence of Serious Physical Assault

(11C) ☐ Substantial Risk of Serious Self-Injurious Behavior

(11D) ☐ Individual Placed Self at Imminent Risk Of Significant Physical Harm

(11E) ☐ Occurrence of Serious Self-Injurious Behavior

*(12) Describe the Individual's Behavior or Other Antecedents Before the Emergency Situation:

_____

_____

_____

_____

_____

*(13) Describe Less Restrictive Methods Used Prior to Restraint:

_____

_____

_____

_____

_____

*(14) Did the Restraint Result in Physical Injury? _____YES ____ NO

*(15) Was an Incident Report Filed? ____YES ____NO

Individual: First Name: _____ Last Name: _____

SECTION II – PHYSICAL RESTRAINTS – **Complete only for Physical Restraints**

*(P1) Describe How the Restraint Intervention was Implemented:

_____

_____

_____

_____

_____

*(P2) Check the Position of Person Restrained During Restraint (check all that apply):

(P2A) ☐ Standing (P2B) ☐ Standing and against wall/mat (P2C) ☐ Sitting (P2D) ☐ Lying Supine (on Back)

(P2E) ☐ Lying on Side (P2F) ☐ Lying Prone (on Stomach) (P2G) ☐ Escort (P2H) ☐ Other, describe below:

_____

*(P3) Was Mechanical or Chemical Restraint Also Used? No____ Yes____

If Yes: Type:_____, Time: am/pm

*(P4) Has Plan to Respond to This Emergency Behavior Been Developed in ISP? No____ Yes____

If Yes, was it followed? Yes____ No____ If not followed, explain why not:

_____

_____

*(P5) Describe Person's Behavior and Condition During Restraint and Safety Checks:

_____

_____

*(P6) Reason for Permanent Removal of Restraint:

_____

_____

*(P7) Describe Behavior and Give Indicators of Individual's Condition After Restraint:

_____

_____

*(P8) Print Names of Involved Parties:

(P8A) Authorizing Initial Restraint/Renewal: _____

(P8B) Applying Restraint:

1. _____
2. _____
3. _____
4. _____

(P8C) Specially Trained Monitor: _____

(P8D) Authorizing Removal: _____

Individual: First Name: _____ Last Name: _____

SECTION II – MECHANICAL RESTRAINT - **Complete only for Mechanical Restraints**

*(M1) Was Physical or Chemical Restraint Also Used? _____YES____NO

If Yes: Type:_____, Time: _____ am/pm

*(M2) Type of Mechanical Restraint Used (Mitts only in the community absent a waiver from the DMR Office for Human Rights):

_____

*(M3) Print Names of Involved Parties:

(M3A) Authorizing Initial Restraint/Renewal: _____

(M3B) Applying Restraint:

1. _____
2. _____
3. _____
4. _____

(M3C) Specially Trained Monitor: _____

(M3D) Authorizing Removal: _____

*(M4) Has Plan to Respond to Behavior Been Developed in ISP? _____YES____NO

If Yes, Was the Plan Followed? ____ YES____NO If No, Explain why the Plan was not followed:

_____

_____

_____

(NOTE: If a plan to respond to behavior has been developed, the Human Rights Committee must have a copy of the plan).

*(M5) Reason For Permanent Removal Of The Restraint:

_____

_____

*(M6) Describe Individual's Condition During Restraint and Safety Checks:

TIME	INDIVIDUAL'S CONDITION	STAFF'S NAME	TIME	INDIVIDUAL"S CONDITION	STAFF'S NAME

(M7) Relief Periods :

START TIME	STOP TIME	INDIVIDUAL'S CONDITION	STAFF'S NAME

Individual: First Name: _____ Last Name: _____

SECTION II – CHEMICAL RESTRAINT - **Complete only for Chemical Restraints**

*(C1) Was Physical or Mechanical Restraint Also Used? ____ YES____NO

If Yes: Type:_____, Time: am/pm

*(C2) Involved Parties:

M.D. Ordering Medication	
Person Administering Medication	
Person Obtaining Telephone Order	

*(C3) Individual's Current Medication Orders per ISP:

_____

_____

*(C4) Special Instructions (Including Significant Medical Problems):

_____

_____

_____

*(C5) Has Plan to Respond to Behavior Been Developed in ISP? ____ YES____NO

If Yes, Was the Plan Followed? ____ YES____NO If No, Explain why the Plan was not followed:

_____

_____

_____

(NOTE: If a plan to respond to behavior has been developed, the Human Rights Committee must have a copy of the plan).

*(C6) Name Of Medication Used: _____

*(C7) Dosage: _____ *(C8) Route : _____

*(C9) Time of Administration: am/pm

*(C10) Describe Individual's Condition During at Time Intervals Ordered By M.D.:

TIME	INDIVIDUAL'S CONDITION	STAFF'S NAME	TIME	INDIVIDUAL"S CONDITION	STAFF'S NAME

Individual: First Name: _____ Last Name: _____

SECTION III – ALL RESTRAINTS

INTERVIEW OF THE INDIVIDUAL:

*Person Interviewing the Individual: _____

*Did the Individual Wish to Comment? ____ YES____NO

If Yes, Comment: _____

_____

_____

_____

If No, or Individual Incapable of Comment, Staff's Interpretation of Individual's Response to Restraint:

_____

_____

_____

_____

SECTION IV – ALL RESTRAINTS – Finalizing Initial Report

*Signature of Person Completing Initial Form: _____

*Date: _____

SECTION V – ALL RESTRAINTS – REVIEWS

***Restraint Manager (HOP) Review and Comment**

(A) To The Best Of Your Knowledge, Were All Procedures And Protocols Followed For This Restraint Action?
_____YES____ NO

(B) If No, areas where this Restraint Action needs improvement (select one or more):

____ Authorization of restraint ____ Renewal Order

____ Monitoring of restraint ____ Restraint training of staff

____ Physical examination of person restrained ____ Other, please describe in Comment Section

(C) Comments or Explanation: _____

_____

_____

_____

Individual: First Name: _____ Last Name: _____

SECTION V – ALL RESTRAINTS – REVIEWS – continued

(D) Date of Review: _____

(E) Signature: _____

Service Coordinator/Area Office – QMRP/Facility Review and Comment

*(A) Complete? _____YES____ NO

*(B) If No, give reason: _____ Inadequate Action Steps _____ Incorrect Categorization

_____ Additional Information Needed _____ Other: (please explain): _____

_____

(C) Once Status is "Complete", please review below:

_____

_____

_____

_____

(D) Date Received By DMR : _____ *(E) Date of Area/Facility Review: _____

*(F) Signature of Area/Facility Reviewer: _____

Human Rights Committee Review and Comments:

_____

_____

_____

_____

*Date of HRC Review: _____ *Signature of HRC: _____

Commissioner's Review and Comments:

_____

_____

_____

_____

*Date of Commissioner's Review: _____

*Signature of Human Rights Specialist Performing Commissioner's Review: _____

Individual: First Name: Last Name:

SECTION VI – CLOSING THE RECORD

*Date Closed: *Closed By: